New Paltz Central School District

196 Main Street, New Paltz, New York 12561
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www.newpaltz.k12.ny.us

Employee Request for Paid Sick Leave and/or Emergency Family and Medical Leave (FFCRA)

Please complete the below request for leave pursuant to the Emergency Paid Sick Leave Act (EPSLA) and/or the Emergency Family and Medical Leave Expansion Act (FMLEA) under the Families First Coronavirus Response Act (FFCRA), and return to the Office of Human Resources at mottavan@newpaltz.k12.ny.us.

Name: ____ **Bldg/Dept:** __________________________

This is a (choose one): New request for leave _______ Request for an extension of leave ________

Anticipated Start Date of Leave: _________________ **Anticipated End Date of Leave:** ______________

I. Reason for Leave (*check all applicable*) I am unable to work for the following reasons:

- ☐ 1.) I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19;
- ☐ 2.) I have been advised by a health care provider to self-quarantine related to COVID-19;
- ☐ 3.) I am experiencing COVID-19 symptoms and seeking a medical diagnosis;
- ☐ 4.) I am caring for an individual subject to an order described in (1) or self-quarantine as described in (2); or
- ☐ 5.) I am caring for a child under 18 whose school or place of care is closed (or child care provider is unavailable) for reasons related to COVID-19.

A. If you selected reasons 1 or 2 above, please provide the name of the governmental entity ordering the quarantine or the name of the health care professional advising self-quarantine. Please also attach a copy of the quarantine order or correspondence from the health care professional advising self-quarantine.

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B. If you selected reason 3 above, paid leave is available only for the time you are unable to work while you are taking affirmative steps to obtain a medical diagnosis. By signing this application form, you are certifying and representing that you will obtain a medical diagnosis as expeditiously as possible, and upon receipt of such diagnosis, you will promptly advise us of any need for continued leave, or your ability to return to work.

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C. If you selected reason 4 above, please provide the name of the governmental entity ordering the quarantine or the name of the health care professional advising self-quarantine, as well as the name of the person for whom you are providing care and their relationship to you. Please also attach a copy of the quarantine order or correspondence from the health care professional advising self-quarantine.

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D. If you selected reason 5 above, please provide the following information:

Name(s) and Age(s) of your Child/Children: ____

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The Name of the School/Place of Care that Closed: _________________________________

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Please also attach documentation indicating that the school or place of care has closed. Examples of acceptable documentation include a notice that has been posted on a government, school, or day care website; a notice published in a newspaper; or an email or a letter from an official of the school, place of care, or child care provider.

By providing the information above and signing this application form, you are certifying and representing that no other person will be providing care for your child or children during the period for which you are receiving leave pursuant to reason 5 above and you will be unable to work or telework in the period of requested leave.

II. **Supplementing Leave with Accrued but Unused PTO**

Please note further that, if you request to take leave for reasons 4 or 5 above, this leave will be at two-thirds your regular rate of pay. If you are granted leave for reasons 4 or 5 above, for the first two weeks, please indicate whether you choose to supplement the two-thirds pay with your accrued but unused paid time off, and if so, the amount you wish to supplement:

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If you are granted leave for reason 5 above beyond two weeks under the FMLEA, you will be required to supplement your two-thirds pay under the FMLEA with your accrued but unused paid time off for the duration of the leave, in accordance with the District Family Medical Leave Act (FMLA) Policy. Such leave credits will automatically be charged on review and approval of your request. Please note that your entitlement to FMLEA leave for reason 5 beyond two weeks will be reduced by any FMLA leave you have taken within the applicable 12-month look back period. Please indicate whether you have taken any FMLA leave within the past 12-month period, and if so, the amount of the FMLA leave taken:

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III. **Certifications**

I certify that, for each of the days that I request leave, I am unable to work because of one of the 5 reasons listed above.

I certify that the above information is accurate and complete:

Employee Signature: ____ Date: ____________